workDo Not Staple!

KENTUCKY EMPLOYEES' HEALTH PLAN PY 2011

ENROLLMENT/CHANGE APPLICATION – RETIREES

www.KEHP.KY.GOV ● 1-888-581-8834

Retiree Coordinator Section

Coverage Effective Date ☐☐ / ☐☐ / 2011 | ☐ KTRS 85000

Reason for Application

☐	New Retiree
☐	Open Enrollment
☐	QE
☐	Other
Reason	

If QE select reason Date of Event ☐☐ / ☐☐ / ☐☐

Deletion of dependent	
☐	Divorce
☐	Death
☐	Loss of eligibility
☐	Gaining other coverage
☐	Gaining Medicare/Medicaid

Other

Reason

Addition of Dependent	
☐	Marriage
☐	Birth/Adoption of child
☐	Guardianship/Ct Order
☐	Loss of other coverage
☐	Loss of KCHIP/Medicaid
☐	Re-establishes eligibility
☐	Special Enrollment

Demographic Information

☐☐☐ - ☐☐ - ☐☐☐☐ **Retiree SSN (required)** | **Retiree Name (First, MI, Last)** | ☐☐ / ☐☐ / ☐☐☐☐ **Retiree Date of Birth**

☐ I am a retiree returning to work | ☐ Retiree is applying for this coverage | If not retiree, what is your relationship to the retiree?

☐☐☐ - ☐☐ - ☐☐☐☐ **Applicant SSN** (If retiree is not applying) | **Applicant Name (First, MI, Last)** | ☐☐ / ☐☐ / ☐☐☐☐ **Applicant Date of Birth**

Mailing Address

City, State, Zip Code

Have you smoked in the last 2 months? ☐ YES ☐ NO

Gender ☐ M ☐ F Marital Status ☐ M ☐

Home or mobile phone number | Work phone number | Email Address

Dependent Information

SOCIAL SECURITY NUMBER	NAME (FIRST, MI, LAST)	BIRTH DATE MONTH/ DAY/ YEAR	GENDER	Cross Reference Payment Option (JRP, LRP not eligible) ☐ YES (Employee, Employee and child(ren))
Spouse		___/___/___	☐ Male ☐ Female	
SP's Company number	☐ Dual Employee ☐ Hazardous Duty	Has spouse smoked in last 2 months ☐ YES ☐ NO		Date of hire/retirement ____/___/___
Child 1		___/___/___	☐ Male ☐ Female	☐ Natural ☐ Adopted ☐ Court Order ☐ Foster ☐ Step ☐ Disabled
Child 2		___/___/___	☐ Male ☐ Female	☐ Natural ☐ Adopted ☐ Court Order ☐ Foster ☐ Step ☐ Disabled
Child 3		___/___/___	☐ Male ☐ Female	☐ Natural ☐ Adopted ☐ Court Order ☐ Foster ☐ Step ☐ Disabled

Plan Election

Benefit Options

- ☐ Commonwealth Optimum PPO
- ☐ Commonwealth Capitol Choice
- ☐ Commonwealth Standard PPO
- ☐ Waiver (No Health Insurance)

Coverage Level

- ☐ Single (self only)
- ☐ Parent Plus (self and child(ren))
- ☐ Couple (self and spouse)
- ☐ Family (self, spouse and child(ren))

FSA

Not Applicable → Retirees are not eligible to participate in a Flexible Spending Account. Cross-referenced with an active employee who wishes to enroll in an FSA? Please complete the enrollment application for active employees instead.

PY 2011

Retiree's SSN ___ – ___ – ____

Applicant's SSN ___ – ___ – ____

Authorization and Certification

I understand and agree that:

- I have made the above plan selection for plan year 2011.
- My signature on this application creates a legal and binding contract between myself, my retirement system, the Department of Employee Insurance (DEI), Kentucky Employees' Health Plan (KEHP) and any TPA.
- If my spouse and I elect the cross-reference payment option, we are dual planholders with Family coverage and that upon a loss of eligibility by either spouse; the remaining planholder will have the option to enroll in either Single or Parent Plus coverage. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/planholder.(This option is not available to LRS/JRS retirees)
- I certify that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the Summary Plan Description(s) and in the KEHP Benefits Selection Guide. I understand that DEI requires supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in the Plan. And, in addition, an affidavit **2011 Certification of Dependent Eligibility** must be submitted for dependent children between the ages of 19-26.
- All benefits for myself and eligible dependents are provided in accordance with the Summary Plan Description (s) and The KEHP Benefits Selection Guide.
- I must abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled and I agree to do so.
- The elections indicated on this application may not be changed or cancelled during the plan year, with the exception of certain Qualifying Events.
- I authorize my Retirement System to deduct from my earnings the amount required to cover my share of the coverage I have selected, including any arrears I may owe.
- I authorize the release of medical claims data to my Retirement System for use in data analysis and referral to available health related services upon their review.
- I authorize my Retirement System to release the information in this application to the Social Security Administration. The information in this application may be used by the Social Security Administration to determine Medicare eligibility. I further acknowledge that Medicare eligibility may affect my participation in the KEHP.
- This plan has a tobacco incentive for members who do not use tobacco and that this plan offers tobacco cessation programs.
- I have rights under HIPAA and that DEI will comply with the HIPAA rules and that disclosure of protected information will be done under the rules of such Federal Law. I further authorize DEI to use such information and to disclose such information to business associates, third party administrators, vendors, consultants, governmental agencies with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities.
- Plan terms permit rescission of coverage with respect to an individual if the individual engages in an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of a material fact.
- Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP and it may be used to reduce or deny a claim or to terminate my coverage.
- I have fully read the materials provided to me. My signature below certifies that all information, signatures and signature dates affixed to this contract are correct to the best of my knowledge.

This application must be signed by a KTRS retirement coordinator. Please mail this application to:

Kentucky Teachers' Retirement System
479 Versailles Road
Frankfort, KY 40601

Retiree Signature	Date
Applicant Signature (if other than retiree)	Date
Spouse Signature – *REQUIRED* if electing the cross-reference payment option	Date
Retirement Insurance Coordinator Signature	Date
Spouse's Insurance Coordinator Signature – REQUIRED if electing the cross-reference payment option	Date